

Arizona Department of Insurance

A Consumer Guide to

Health Care Appeals



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OUTLINE OF THE HEALTH CARE APPEALS PROCESS IN ARIZONA

This brochure is intended to provide a brief description of the health care appeals process. A more detailed explanation is provided in the Health Care Appeals Information Packet available from your health insurer. If you file a complaint with the Department of Insurance related to a denial that is subject to the appeals process, the Department must first require you to pursue the appeals process at your insurer. The Department will not otherwise address your complaint during the appeals process, except to the extent your complaint alleges an independent violation of the Insurance Code other than the denial of your claim or request for service.

What Is the Health Care Appeals Process?

Arizona law requires health insurers, HMOs, dental plans, prepaid dental plans and vision plans to provide their insured members with a way to appeal denied claims or denied services. A “denied claim” is when you have already received care, submitted a claim, and the insurer has denied the claim. A “denied service” is when the plan refuses to authorize a service that is covered by the plan, such as a referral to a specialist, or the plan refuses to pre-authorize any treatment or procedure that you or your doctor believe is medically necessary and covered by your policy. When your health insurer denies a claim or service, it must advise you of your right to appeal the denial. Please keep in mind that the appeals process will normally *not* occur unless *you* (or your provider) have specifically requested that your insurer or plan reconsider its decision. The appeals process generally consists of the following levels of review:

For urgently needed services not yet provided:

1. Expedited Medical Review
2. Expedited Appeal
3. Expedited External Independent Review

For standard services or denied claims

1. Informal Reconsideration
2. Formal Appeal
3. External, Independent Review

URGENTLY NEEDED SERVICES NOT YET PROVIDED

Expedited Medical Review

Expedited Medical Review will only apply to denied services when your doctor (or treating provider) certifies in writing that delaying the needed health care service could cause a significant negative change in your medical condition. The insurer or health plan must make a decision within one business day after receiving your doctor's certification and any supporting documentation, and notify you and your doctor of the decision in writing. If your insurer or health plan still believes that it should not cover the requested service after

the Expedited Medical Review is completed, it must inform you by phone and in writing of your right to then request an Expedited Appeal, which is described below.

Expedited Appeal

If the insurer denies the requested service following the Expedited Medical Review and you still wish to appeal the denial, your treating provider must immediately submit a written appeal to the health plan and provide any additional justification or documents supporting the request for service. The insurer or health plan must make a decision within three business days after receiving the provider's appeal request. If the insurer upholds its denial following the Expedited Appeal, the insurer must inform you and your provider by phone and in writing of the denial and of your right to immediately proceed to an Expedited External Independent Review.

Expedited External Independent Review

You have five business days after you are notified that your Expedited Appeal was denied to request an Expedited External Independent Review. Your insurer will send a copy of all relevant medical records, your policy and any supporting documentation used to make its earlier decision to the Arizona Department of Insurance within one business day of receiving your Expedited External Independent Review request.

For medical necessity cases, the Department of Insurance will forward submitted materials to an independent review organization selected by the Department within two business days of receiving them. The reviewing organization, under contract with the State of Arizona to provide services to the Department of Insurance, is not connected to your health insurance company. The Department will pay the independent review organization, and will recover its costs from your health insurance company. The external, independent reviewer must generally be a doctor who is board certified or board eligible

in his or her specialty. The reviewer may not have *any* conflict of interest that will preclude the reviewer from making a fair and impartial decision. The reviewer has five business days to notify the Department of Insurance of its decision. The Department then has one business day from when it receives the external, independent reviewer’s decision to notify you, your doctor (or treating provider) and your insurer of the reviewer’s decision.

For cases involving denials based on a question of coverage, the Department of Insurance has two business days to review the information provided and determine if the denied service or claim is covered under the policy. The Department will notify you, your doctor (or treating provider) and your insurer of its decision.

STANDARD SERVICES OR DENIED CLAIMS

Informal Reconsideration

Informal Reconsideration is the first step in the appeals process for denied services when you do not qualify for Expedited Medical Review. You may request Informal Reconsideration by calling, writing or faxing your request to your insurer. You have up to two years after your insurer denies your request for a covered service to request an Informal Reconsideration. The insurer has 30 days to make a decision and notify you and your doctor or treating provider of that decision. For denied claims, some insurers may allow you to go through the Informal Reconsideration process, or they may require that you go straight to a Formal Appeal. If the insurer still denies your request for service (or claim, if applicable) after the Informal Reconsideration is completed, you may then request a Formal Appeal.

Formal Appeal

If your insurer denies your request for a covered service after an Informal Reconsideration, you may request a Formal

Appeal. You have 60 days following the completion of the Informal Reconsideration of a denied service to request a Formal Appeal. If your insurer requires appeals of denied claims to begin at the Formal Appeal level, you have up to two years after the last denial occurred to request a formal appeal of your denied claim. For denied services, your insurer has 30 days to make its decision. For denied claims, the insurer has 60 days to make its decision and notify you of the decision. If the insurer still denies your request for service or a claim for a service, you can then request an External, Independent Review.

External, Independent Review

You have 30 days after your insurer notifies you that your Formal Appeal was denied to request an External, Independent Review. Your insurer will send a copy of all relevant medical records, your request for review, your policy and any supporting documentation used to make its earlier decision to the Department of Insurance within five business days of receiving your External Independent Review request.

For medical necessity cases, the Department of Insurance will forward submitted materials to an independent review organization selected by the Department within five business days of receiving them. The reviewing organization, under contract with the State of Arizona to provide services to the Department of Insurance, is not connected to your health insurance company. The Department will pay the independent review organization, and will recover its costs from your health insurance company. The external, independent reviewer must generally be a doctor who is board certified or board eligible in his or her specialty. The reviewer may not have any conflict of interest that will preclude the reviewer from making a fair and impartial decision. The reviewer has 21 days to notify the Department of Insurance of its decision. The Department of Insurance then has five business days from when it receives

the external, independent reviewer’s decision to notify you, your doctor (or treating provider) and your insurer of the reviewer’s decision.

For cases involving denials based on a question of coverage, the Department of Insurance has 15 business days to review the information provided and determine if the denied service or claim is covered under the policy. The Department will notify you, your doctor (or treating provider) and your insurer of its decision. If the Department is unable to determine if the claim is covered under the policy, it may then send the case to an independent review organization. If that happens, the reviewer has 21 days to send a decision to the Department and you would be notified of the decision within five business days.

The external, independent reviewer’s decision is legally binding on the insurer and you, even if you or the insurer disagrees with the decision. Either you or the insurer may go to court following the completion of the external, independent review based on an issue of medical necessity. If you or the insurer disagree with the Department of Insurance’s decision regarding coverage issues, either party may request a hearing with the Office of Administrative Hearings. Hearings must be requested within 30 days of receiving the coverage issue determination. Instructions for requesting a hearing will be sent to you along with notice of any decision made by the Department of Insurance. **Please keep in mind, however, that the independent review organization, the Department of Insurance and the Office of Administrative Hearings cannot require an insurer to pay a claim or provide a service that is excluded from coverage by your policy.**

What doesn’t qualify for the appeals process?

Those with coverage through a Medicare HMO, Medicare supplement plan, long-term care coverage, a multi-employer plan under

ERISA, a federal employee plan, or any self-funded or self-insured plan are not eligible to participate in the appeals process described in this brochure. Workers’ Compensation claims and disputes are also not eligible for this appeals process. These other plans normally do have an appeals process of some kind that you may use, but the appeals process in those other plans will probably be somewhat different from what is described in this brochure. Issues concerning how you were treated by a provider, benefit reductions due to usual and customary charge limitations, deductibles, and coordination of benefits issues are also not eligible for health care appeals. If you merely have questions regarding your plan, you should call the member services department of your insurer.

Helpful Hints

If you decide to file an appeal with your insurer, make sure to include as much supporting documentation as possible that shows why you believe the denied service or claim should be covered. When filing an Expedited Medical Review, you must include the doctor’s written certification that delaying treatment will negatively impact your medical condition. Remember that you cannot request an External, Independent Review before you have completed any applicable Formal Appeal, Informal Reconsideration or Expedited Medical Review.

Please also keep in mind that this is only a brief description of the way the appeals process will generally work at most insurers. There can be some variation from company to company. Please refer to the Health Care Appeals Information Packet available from your insurer for more specific details regarding how your insurer handles appeals.

Persons with a disability may request that materials be presented in an alternative format by contacting the ADA Coordinator at (602) 364-3471. Requests should be made as early as possible to allow time to procure the materials in an alternate format.